## Attachment B-6

MAPB-037-015-D/002-HA Date: 9/1/37

MAIL TO: E.D.S. FEDERAL CORPORATION

DATE

## PRIOR AUTHORIZATION **REQUEST FORM**

1. PROCESSING TYPE

PRIOR AUTHORIZATION UNIT 6406 BRIDGE ROAD SUITE 88 MADISON, WI 53784-0088			1	PA/RF (DO NOT WRITE CN # A.T. # P.A. # 1234567	TE IN THIS SP	ACE)		113
2 RECIPIENT'S MEDICAL ASSIST	ANCE I.D.	NUMBER			4. RECIPIEN	IT ADDRESS (STRE	ET, CITY, STATI	E, ZIP CODE)
3. RECIPIENT'S NAME (LAST, FIR	ST. MIDDL	E INITIAL)			609	Willows		•
Recipient, Ima					Anyt	town, WI	53725	
5. DATE OF BIRTH				6. SEX 7. BILLING PROVIDER TELEPI				
MM/DD/YY				M F X ( XXX ) XXX-				
8. BILLING PROVIDE NAME, ADD	RESS. ZIP	CODE:				9. BILING PROVI	OR RE	
I. M. Provider						11. DX: SECONDA	- Hearing Loss AY - Hearing Problem	
1 W. Williams			12 START DATE O				13. FIRST DATE RX:	
Anytown, WI 5	3725					12 START DATE	r 301.	IS. FINST ONTE TIA.
		1.0		18			19	20
PROCEDURE CODE	MOD	POS	TOS		RIPTION OF SERVICE			CHARGES
92585		3	W Evoked Response Audiometry				1	XX.XX
					·-,			
					·			
An approved authorization does not guarantee payment.  Reimbusement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.  21 I. M. Provider  REQUESTING PROVIDER SIGNATURE								
				(DO NOT WRITE IN	THIS SPAC	<b>E</b> )		
AUTHORIZATION:  APPROVED  GRANT DATE  EXPIRATION DATE  PRODEDURE(S) AUTHORIZED QUANTITY AUTHORIZED  EXPIRATION DATE								
MODIFIED - REASO	N:					·		

CONSULTANT/ANALYST SIGNATURE